



Understanding National Health Reform

Joint Legislative Oversight Committee
for Mental Health, Developmental
Disabilities and Substance Abuse
Services

Presentation by:
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North Carolina Institute of Medicine
October 13, 2010





A Word About the NC Institute of Medicine

- Quasi-state agency chartered in 1983 by the NC General Assembly to:
 - Be concerned with the health of the people of North Carolina
 - Monitor and study health matters
 - Respond authoritatively when found advisable
 - Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

NCGS §90-470





Background

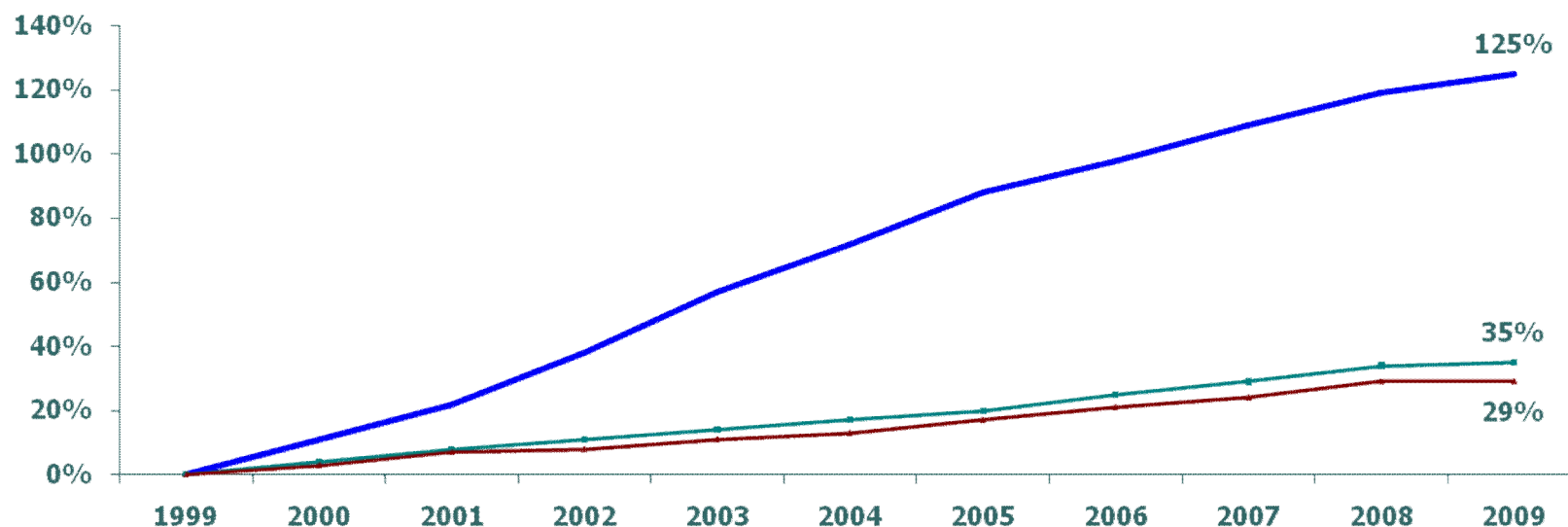
- Estimates of the uninsured:
 - Recent Census numbers showed approximately 1.7 million non-elderly uninsured in NC (2009)
- Lack of health insurance impacts on a person's health
 - People who are uninsured are less likely to receive preventive services, more likely to end up in the hospital for preventable conditions or late stage cancer, and more likely to die prematurely
 - Lack of insurance coverage affects a family's financial security



Source: US Census. Health Insurance Coverage Status and Type of Coverage by State—Persons Under 65. Table HIA-6.



US Health Insurance Premiums Increasing More Rapidly Than Inflation or Earnings (1999-2009)



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008 (April to April). Claxton G. et. al. Job-Based Health Insurance: Costs Climb at a Moderate Rate. Health Affairs. Sept. 15, 2009.

— Health Insurance Premiums
— Workers' Earnings
— Overall Inflation



National Health Reform Legislation

- Patient Protection and Affordable Care Act (HR 3590) (signed into law March 23, 2010)
- Health Care and Education Affordability Act of 2010 (HR 4872)



Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- Private coverage
- Other provisions
- CBO estimates
- North Carolina planning efforts
- Impact on people with MH/DD/SA



Basics of National Health Reform--Overview

- **Overview of health reform legislation**
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● ● ● | Overview of Health Reform

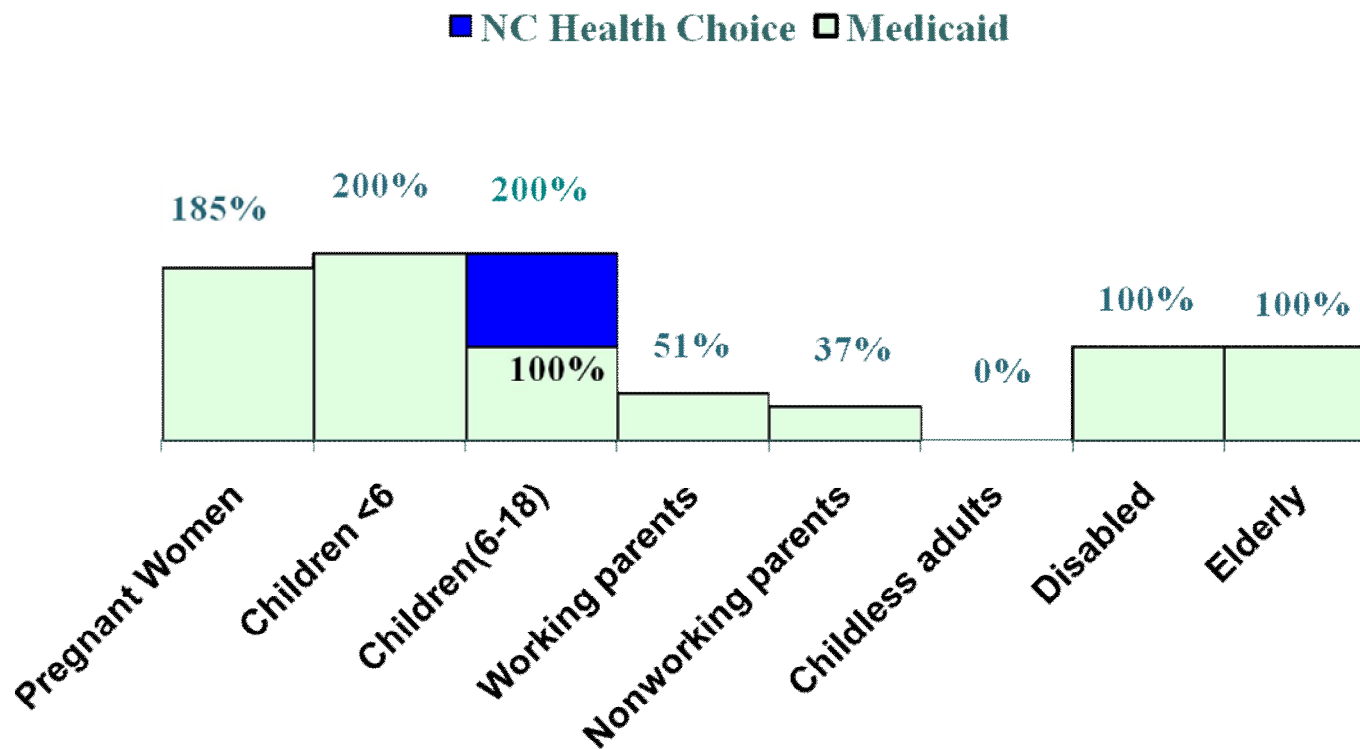
- By 2014, the bill requires most people to have health insurance and large employers (50+ employees) to provide health insurance--or pay a penalty.
 - Builds on our current system of public coverage, employer-sponsored insurance, and individual (non-group) coverage
- New funding for prevention, expansion of the health workforce, long-term care services, increasing the healthcare safety net, and improving quality



Basics of National Health Reform--Overview

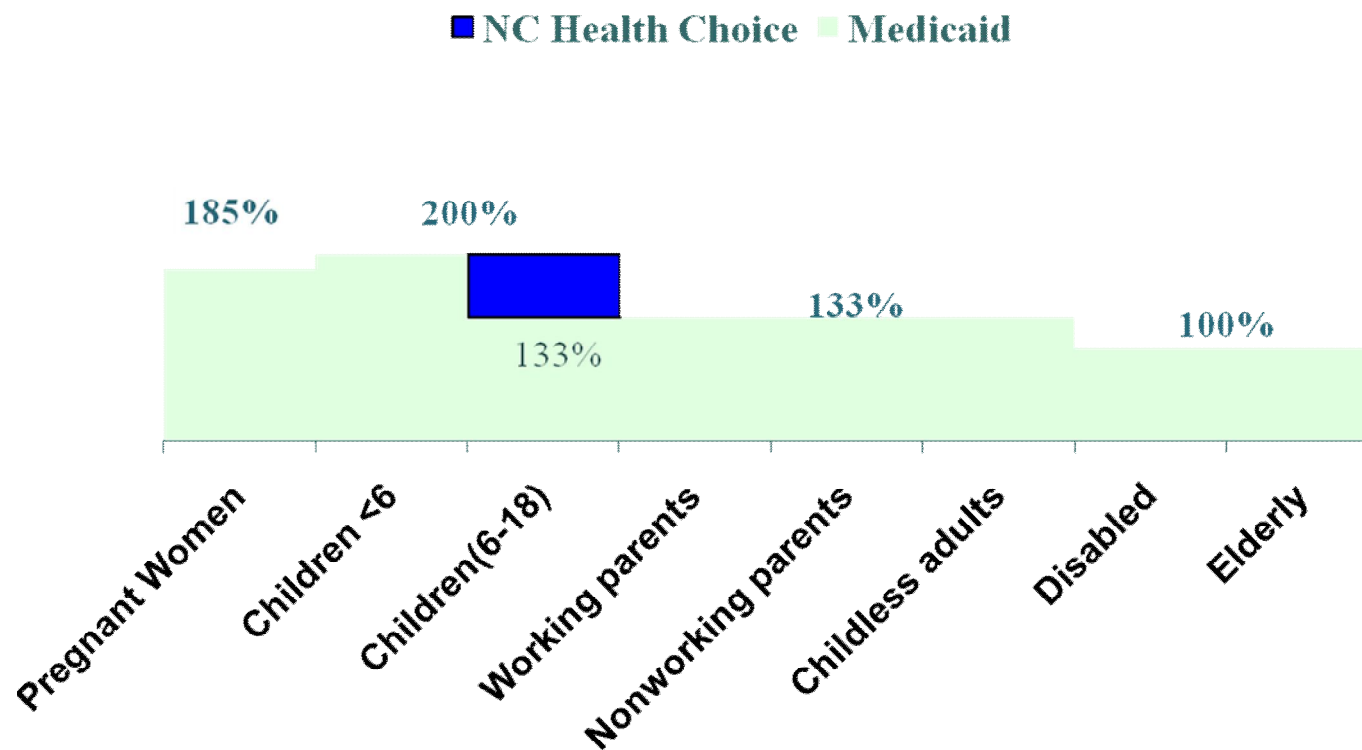
- Overview of health reform legislation
- **Changes in public coverage**
 - **Medicaid, CHIP and Medicare**
- Private coverage
- Other provisions
- CBO estimates
- NC planning efforts
- Impact on people with MH/DD/SA

Existing NC Medicaid Income Eligibility (2010)



Currently, childless, non-disabled, non-elderly adults can not qualify for Medicaid

Existing NC Medicaid Income Eligibility (2014)



Beginning in 2014, adults can qualify for Medicaid if their income is no greater than 133% FPL, or \$29,327 for a family of four



Expansion of Public Programs

- Expands Medicaid to cover all low-income people under age 65 (including childless adults) with incomes up to 133% FPL (begins FY 2014) (Secs. 2001, 2002)
 - States must maintain current income eligibility for children in Medicaid and CHIP until 2019 (Sec. 2101(b), 10203).
 - Beginning 2014, special outreach requirements to vulnerable populations, **including people with mental illness or substance use disorders** (Sec 2201).



Medicare

- Enhances preventive services, beginning Jan. 2011 (Sec. 4103-4105, 10402, 10406)
- Phases out the gap in the Part D “donut hole” by 2020 (Sec. 3315, as amended by 1101 Reconciliation)
 - \$250 rebate in 2010
 - 50% discount on brand-name drugs in 2011 (Sec. 3301)
- Strengthens the financial solvency of the Medicare program
 - Extends the life of the Medicare trust fund by 12 years



Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- **Private coverage**
 - **Standardized benefit package**
 - **Individual mandate and subsidies**
 - **Employer responsibilities**
 - **Health insurance “exchanges” and insurance reform**
- Other provisions
- CBO estimates
- NC planning efforts



Essential Benefits Package

- HHS Secretary will recommend an essential health care benefits package that includes a comprehensive set of services: (Sec. 1302; Sec. 2713 of Public Health Service Act, amended in Sec. 1001)
 - Hospital services; professional services; prescription drugs; rehabilitation and habilitative services; and maternity care
 - More extensive services for children under age 21 (Sec. 1001, 1302)
 - Recommended preventive services with no cost-sharing and all recommended immunizations (Sec. 1001, 10406)
 - **Mental health parity law applies to qualified health plans** (Sec. 1311(j))



Essential Benefits Package

- Four levels of plans, all must cover essential benefits package: (Sec. 1302(d))
 - Bronze (minimum creditable coverage): must cover 60% of the benefit costs of the plan
 - **Silver: 70% of the benefits costs***
 - Gold: 80% of the benefit costs
 - Platinum: 90% of the benefit costs



Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance, unless exempt. (Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)
 - Penalties: Must pay the greater of: \$95/person or 1% taxable income (2014); \$325 or 2.0% (2015); or \$695 or 2.5% (2016), increased by cost-of living adjustment*
 - Some of the exemptions include people who are not required to file taxes, and those for whom the lowest cost plan exceeds 8% of an individual's income (Sec. 1501(d)(2)-(4),(e))



*Families of 3 or more will pay the greater of the percentage of income, or three times the individual penalty amount. The maximum penalty is equal to the amount the individual or family would have paid for the lowest cost bronze plan (minus any allowable subsidy).



Subsidies to Individuals

- Refundable, advanceable premium credits will be available to individuals with incomes up to 400% FPL on a sliding scale basis (\$43,320/yr. for one person, \$58,280 for two, \$73,240 for three, \$88,200 for a family of four in 2010).* (Sec. 1401, as amended by Sec. 1001 of Reconciliation)
- Individuals are generally not eligible for subsidies if they have employer-based coverage, TRICARE, VA, Medicaid, or Medicare (Sec. 1401(c)(2)(B)(C), 1501)
- In comparison: North Carolina's median household income in 2008 was \$46,574 (avg. household = 2.5 people).



*2010 Federal Poverty Levels are: \$10,830 for an individual, \$14,570 for a family of two, \$18,310 for a family of three, or \$22,050 for a family of four. US Census Bureau. North Carolina. Quick Facts.
<http://quickfacts.census.gov/qfd/states/37000.html>

● ● ● | Employer Responsibilities

- Employers with 50 or more full-time employees required to offer insurance or pay penalty (Sec. 1201, 1513, amended Sec. 1003 Reconciliation)
- Employers with less than 50 full-time employees exempt from penalties. (Sec. 1513(d)(2))
 - Employers with 25 or fewer employees and average annual wages of less than \$50,000 can receive a tax credit. (Sec. 1421, Sec. 10105)

● ● ● | Health Insurance Exchange

- States will create a Health Insurance Exchange for individuals and small businesses. (Sec. 1311, 1321)
 - Limited to citizens and lawful residents who do not have access to employer-sponsored or governmental-supported health insurance and to small businesses with 100 or fewer employees. (Sec. 1312(f))
- Exchanges will:
 - Provide standardized information (including quality and costs) to help consumers choose between plans
 - Determine eligibility for the subsidy



Health Insurance Exchange (HBE)

- “No wrong door approach” between Medicaid and HBE (Sec. 1311, 1411, 1413)
 - Individuals who apply for health insurance through the HBE will have their eligibility determined for Medicaid; those who apply for Medicaid will have their eligibility determined for HBE subsidies
- Patient navigators to help link individuals to Medicaid or private insurance through HBEs



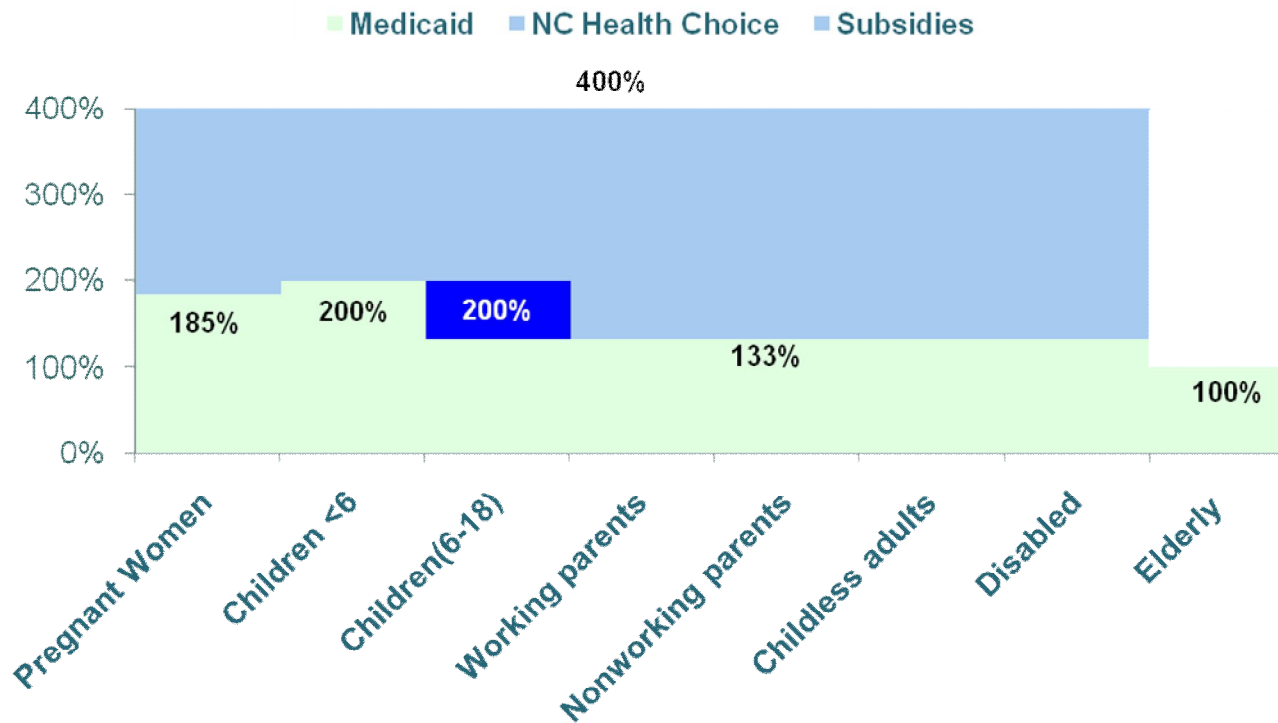
Immediate Insurance Reform

- The ACA included immediate changes in insurance laws which may help some people with MH/DD/SA conditions
 - Funding for a federal high risk pool that provides more affordable coverage to people with preexisting health problems (Effective July 1, 2010, Sec. 1101)
 - Insurers cannot exclude children based on their preexisting health problems (effective for plans renewed or purchased after September 23, 2010)
 - Insurers cannot impose lifetime limits on health coverage, and must limit annual limits, and cannot rescind policies (effective for plans renewed or purchased after September 23, 2010, Sec. 2711 , 2712, of the Public Health Service Act as amended by Sec. 1001 of ACA)

● ● ● | Insurance Reform: 2014

- Insurers are prohibited from:
 - Discriminating against people based on preexisting health problems (Effective 2014; Sec. 1201)
 - Including annual or lifetime limits for essential benefits (Sec. 1001, 10101)
- Insurers are required to:
 - Limit the differences in premiums charged to different people based on age (3:1 variation allowed), and certain other rating factors (Effective 2014; Sec. 1201)

After Health Reform Fully Implemented (Beginning 2014)



Beginning 2014, most people with incomes $\leq 400\%$ FPL who do not have Medicaid, Medicare, Health Choice, TRICARE, or access to employer-based coverage can qualify for subsidies to purchase insurance in the Exchange



Income Eligibility for Subsidized Insurance (2010, 2014)

Annual income eligibility based on family size of four
(based on 2010 federal poverty levels)

	<u><i>Current:</i></u> Eligibility for Medicaid or NC Health Choice (2010)	<u><i>New:</i></u> Eligibility for Medicaid or NC Health Choice (2014)	<u><i>New:</i></u> Eligibility for Subsidy in the Health Benefit Exchange (2014)
Child	≤\$44,100	≤\$44,100	\$44,100-\$88,200
Parent of dependent child	≤\$11,246	≤\$29,327	\$29,327-\$88,200
All other adults (non-disabled, non-elderly)	Not eligible	≤\$29,327	\$29,327-\$88,200



Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- Private coverage
- **Other provisions**
 - **Prevention and Wellness; Workforce; Quality and New Models of Care; Safety Net; Long-Term Care; Other Provisions; States' Roles**
- CBO estimates
- NC planning efforts
- Impact on people with MH/DD/SA



Prevention: Mental Health & Substance Abuse

- Appropriates funds for a Prevention and Public Health Fund (\$500M FY 2010-\$2B FY 2015) to invest in prevention, wellness, and public health activities (Sec. 4002)
 - Priority areas for the national public health agenda includes health promotion and disease prevention to address lifestyle behavior modification (including smoking cessation, proper nutrition, exercise, **mental health, behavioral health, substance use disorder,** and domestic violence screenings) (Sec. 4001)
 - Half of the public health trust fund used to help support workforce initiatives in 2010

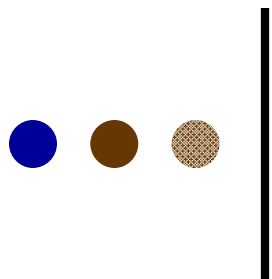
● ● ● | Workforce Overview

- Increased efforts to expand and promote better training for the health professional workforce
 - Includes loan forgiveness and scholarships to train primary care, pediatrics, geriatrics, nursing, dental health, public health, **mental health/substance abuse**, allied health and direct care workforce
 - Increased emphasis on increasing the supply of health professionals in underserved areas
 - Enhanced training in prevention, quality initiatives, interdisciplinary care, community based education, and diversity



Workforce: Underserved Areas

- National Health Service Corps: appropriates a total of \$1.5B over 5 years (FY 2011-2015) (Sec. 5207, 10503)
 - Loan forgiveness for agreeing to serve in health professional shortage areas (HPSAs)
 - Eligible providers include: primary care, dental, **psychiatric (physician and mid-level providers), plus psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors**



Quality

- HHS Secretary will establish national strategy to improve health care quality (Sec. 3011, 3012)
 - Funding to CMS to develop quality measures (i.e., health outcomes, functional status, transitions, consumer decision making, meaningful use of HIT, safety, efficiency, equity and health disparities, patient experience) (Authorizes \$75M for each FY 2010-2014; Sec. 3013-3014)
 - Plan for the collection and public reporting of quality data (Sec. 3015, 10305, 10331)
 - Funding to support comparative effectiveness research

● ● ● | New Models Overview

- Efforts to test new models of care to improve quality and efficiency (Sec. 3021, 10306)
 - Some of the new models include: payment and practice reform in primary care, **reverse co-location (primary care in community mental health agencies), care coordination and community-based teams for chronically ill individuals including people with mental illness, emergency psychiatric coverage in institutions for mental diseases**, payment reform
 - Appropriates \$5 million (FY 2010) for design and implementation of models and \$10 billion to implement those models (FY 2011-2019)



Safety Net

- New funding to expand federally qualified health centers (also called community health centers)
(Sec. 10503, Sec. 2303 of Reconciliation)
 - Appropriates a total of \$9B over five years for operations (\$1B in FY 2011 increasing to \$3.6B in FY 2015); and \$1.5B over five years for construction and renovation of community health centers (FY 2011-2015) (Sec. 10503, Sec. 2303 of Reconciliation)
- Other support for safety net organizations, but nothing in the bill directly targeted to community mental health agencies

● ● ● | Long-Term Care

- Establishes a national voluntary insurance program to purchase community living assistance services and supports (CLASS) financed through payroll deduction. (Sec. 8001-8002, 10801)
- New Medicaid state options to expand home and community-based services
 - Federal government provides an enhanced federal match rate to expand home and community based services to people who would otherwise need to be institutionalized (including ICF-MRs)



Long-Term Services and Supports

- Community First Choice option (Sec. 2401):
 - States can receive an increase in the FMAP rate by 6 percentage points (Effective 10-1-2011)
 - Will help pay for home and community based *attendant services and supports* for individuals with incomes <150% FPG who would otherwise need institutionalization (nursing home, hospitalization, **ICF-MR, or institution for mental disease**)
- State Balancing Initiative (Sec. 10202):
 - NC can receive an increase in its FMAP rate by 2 percentage points
 - NC would need to ensure that at least 50% of LTC Medicaid funds were spent on home and community based services



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Congressional Budget Office (CBO) Projections

- Covers 92% of all nonelderly residents (94% of legal, nonelderly residents)
 - Would cover an additional 32 million people (leaving 23 million nonelderly residents uninsured by 2019)
- Expansion of insurance coverage and new appropriations included in PPACA will cost \$938 billion over 10 years.
 - However, with new revenues and other spending cuts, PPACA is estimated to reduce the federal deficit by \$124 billion over 10 years.*



* More recent CBO estimate suggests that costs would increase by \$115 billion over 10 years *if* Congress funds all the provisions that are authorized at certain levels but not yet appropriated. Sources: CBO letter dated March 20, 2010, May 11, 2010.



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● ● ● | Health Reform Workgroups

- Public-private workgroups convened to how to best implement health reform in North Carolina
- *Overall Advisory Committee:*
Co-Chairs: Secretary Lanier Cansler, CPA; Insurance Commissioner Wayne Goodwin, JD
- *Eight work groups:*
Health Benefit Exchange and Insurance Oversight;
Health Professional Workforce; Medicaid Provisions
and Elder Law; New Models of Care; Prevention;
Quality; Safety Net; Fraud and Abuse



Health Reform Workgroups

- The overall goal is to ensure the decisions made in implementing the federal health reform legislation serves the best interests of the state as a whole. To do this, the workgroups will:
 - Identify the decisions the state must make in implementing the national legislation.
 - Identify potential funding opportunities
 - Make recommendations to the legislature and executive agencies about options to help North Carolina improve population health, access to care, and health care quality, while slowing health care costs.



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- Cost containment and financing
- CBO estimates
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- **Impact on people with MH/DD/SA**

● ● ● | **Summary: Impact on People with MH/DD/SA Conditions**

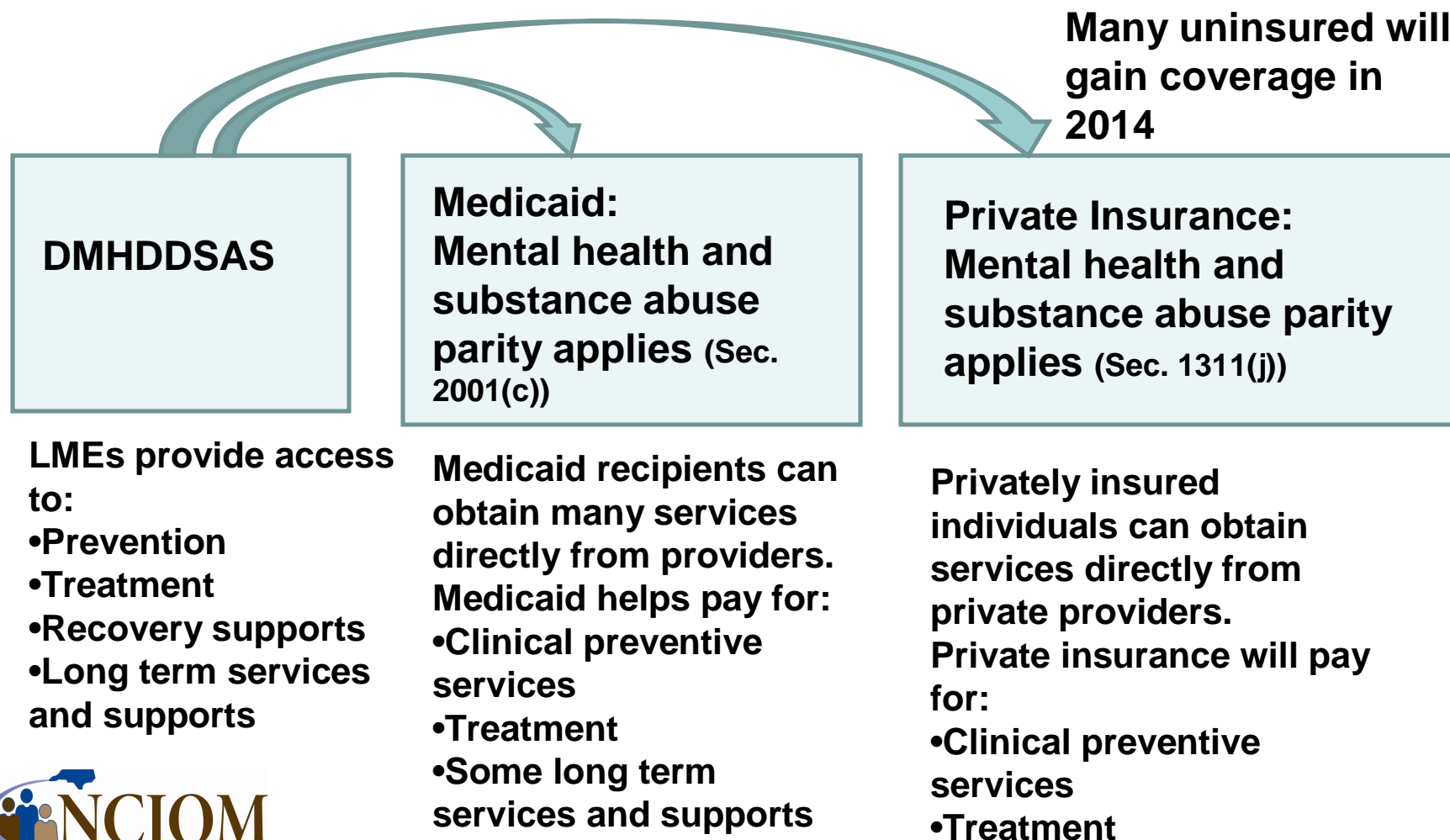
- Insurance coverage will be expanded
 - All qualified health plans sold in the health benefit exchange must provide treatment for **mental health and substance use disorders in parity** to other physical illnesses
 - Preventive services recommended by the US Preventive Services Task Force must be offered with no cost sharing. This includes: **screening and counseling to reduce alcohol misuse in adults, and screening for depression in adults and adolescents**
 - No lifetime or annual limits for essential health benefits

● ● ● | **Summary: Impact on People with Behavioral Health Conditions**

- Many people who are currently uninsured and receive services through LMEs will be eligible for Medicaid or private insurance coverage
 - This means that fewer people will need to access clinical treatment services for mental health and substance use disorders through LMEs
 - LMEs will still have a major role to play in authorizing services to people who continue to lack insurance coverage, authorizing wrap-around services not covered through Medicaid or traditional insurance (such as recovery supports), and in utilization management



Potential Impact on MHDDSAS Delivery System





ACA Potential Impact on MHDDSAS Delivery System

○ Outstanding questions:

- 1) What proportion of the LME clients will gain Medicaid or private insurance coverage?
- 2) What gaps will remain in mental health, developmental disabilities or substance abuse services that will not be covered by Medicaid or private insurance?
- 3) Will some of the current state IPRS dollars be “freed up” to fill gaps in services not covered through Medicaid or private insurance coverage?
- 4) What is the role of the LME in the new system?



Questions



NCIOM Health Reform Resources

- What Does Health Reform Mean for North Carolina?
North Carolina Medical Journal, May/June 2010;71:3
- NCIOM: North Carolina data on the uninsured
<http://www.nciom.org/data/uninsured.shtml>
- Other resources on health reform are available at:
www.nciom.org/data/healthreform.php





Structure of the Health Reform Workgroups

- The NC Department of Health and Human Services and the NC Department of Insurance is taking the lead in establishing these workgroups.
- The effort will be led by an overall advisory group, led by:
 - **Lanier Cansler, CPA**
Secretary
North Carolina Department of Health and Human Services
 - **Wayne Goodwin, JD**
Insurance Commissioner
North Carolina Department of Insurance



Health Benefit Exchange and Insurance Oversight

- Co-Chairs:

- Louis Belo
Chief Deputy Commissioner
North Carolina Department of Insurance
- Allen Feezor
North Carolina Department of Health and Human Services

- Charge:

- Development of the Health Benefit Exchange
- Provide guidance on insurance oversight
- Coordinate enrollment between Medicaid and the Exchange
- Provide guidance on the new insurance ombuds program, and the creation of patient navigator programs





Health Professional Workforce

○ Co-Chairs:

- Tom Bacon, DrPH
Director
North Carolina Area Health Education Centers Program
- Kennon Briggs
Executive Vice President and Chief of Staff
North Carolina Community College System
- Alan Mabe, PhD
Vice President for Academic Planning
UNC General Administration
- John Price
Director, NC Office of Rural Health and Community Care
NC Department of Health and Human Services





Health Professional Workforce

- Charge:
 - Examine funding opportunities for workforce development, including but not limited to: primary care, nursing, allied health, behavioral health, dentistry, public health, direct care workforce
 - Outreach about loan repayment opportunities
 - Identify best models for quality improvement and interdisciplinary training in workforce development programs
 - Fostering collaboration and coordinating implementation



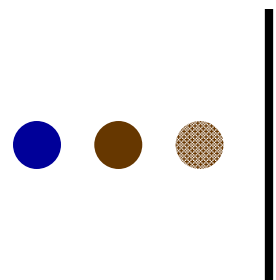
Medicaid and Elder Services

- Co-Chairs:

- Craigan Gray, MD, JD, MBA
Director, NC Division of Medical Assistance
NC Department of Health and Human Services

- Charge:

- Identify implementation steps for Medicaid expansion
- Coordinate enrollment between Medicaid and the Exchange
- Explore Medicaid state options to expand services, including but not limited to: prevention, home and community-based services
- Examine funding opportunities for Elder Justice Act



New Models of Care

- Co-Chairs:

- Allen Dobson, MD
Vice President, Clinical Practice Development
Carolinas HealthCare System
- Craigan Gray, MD, MBA, JD
Director, Division of Medical Assistance
NC Department of Health and Human Services

- Charge:

- Explore new methods of financing care, including accountable care organizations, bundled payment, global payment
- Explore new methods of delivering care, including patient centered medical home, coordinated care for chronic illness, medication management





Prevention

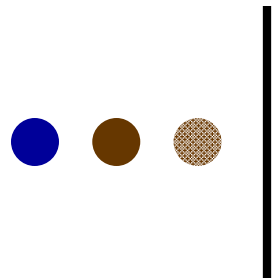
- Co-Chairs:

- Jeffrey Engel, MD
State Health Director
Division of Public Health
NC Department of Health and Human Services
- Laura Gerald, MD, MPH
Executive Director
Health and Wellness Trust Fund

- Charge:

- Identify funding opportunities for prevention and wellness programs
- Identify communities of greatest need
- Encourage collaboration in funding opportunities





Quality

- Co-Chairs:

- Alan Hirsch, JD
Executive Director
NC Healthcare Quality Alliance
- Sam Cykert, MD
Associate Director for Medical Education
NC Area Health Education Centers Program

- Charge:

- Understand federal guidelines for patient outcome quality measures and reporting requirements
- Identify strategies to improve quality of care provided to meet the new quality requirements
- Build on existing state quality initiatives





Safety Net

- Co-Chairs:

- Chris Collins

Deputy Director, Office of Rural Health and Community Care
Assistant Director, NC Division of Medical Assistance
NC Department of Health and Human Services

- Ben Money, MPH

Executive Director
NC Community Health Center Association

- Charge:

- Explore new opportunities for community-based collaborative networks of care
- Examine new requirements for safety net providers
- Identify areas of the state with greatest unmet need, and encourage collaboration in funding opportunities





Fraud and Abuse

- Co-chairs:

- Al Koehler
Chief Investigator
NC Department of Insurance
- Tara Larson, MAEd
Chief Clinical Operations Officer
NC Division of Medical Assistance
NC Department of Health and Human Services

- Charge:

- Examine new program integrity provisions under Medicaid, Medicare (as it affects the state), and insurance
- Identify implementation steps to meet new federal requirements
- Understand and educate providers on financial integrity and fraud and abuse reporting requirements

